Kansas Department of Health and Environment
Ryan White Title II CARE Program
1000 SW Jackson, Suite 210 Topeka, KS 66612-1274
(785) 296-8891

Kansas Department of Health and Environment
HIV Surveillance Program
1000 SW Jackson, Suite 210 Topeka, KS 66612-1274

KANSAS RYAN WHITE TITLE II/ADAP MEDICAL ELIGIBILITY FORM

PATIENT INFORMATION (THIS INFORMATION CAN BE COMPLETED BY CASE MANAGEMENT)

Name (Last, First, MI)

Physical Address

City State Zip Code

Mailing Address ☐ Not Applicable

City State Zip Code

Gender (Check One) ☐ F ☐ M ☐ T Social Security Number

Diagnostic Status at Report: (Check One) ☐ HIV Infection Years: ☐ AIDS Years:	Date of Birth (mm/dd/yy):	

If the information represents an HIV report where a person has not progressed to an AIDS diagnosis, a case report WILL need to be completed when/if and the person progresses clinically to an AIDS diagnosis.

Race (Check all that apply)

☐ American-Indian / Alaska Native ☐ Black and African-American ☐ Asian ☐ Native Hawaiian / Pacific Islander

☐ White ☐ Other:

Ethnicity (Check One) ☐ Hispanic ☐ Not Hispanic/Latino/a ☐ Unknown

Country of Birth

☐ U.S. ☐ U.S. Dependencies and Possessions (including Puerto Rico) ☐ Other:

For Office Use ONLY: MedLegNo: _____ Entered: _____ Expired: _____

PATIENT HISTORY (THIS INFORMATION CAN BE COMPLETED BY CASE MANAGEMENT)

Name of Facility of Diagnosis | City | State/Country

Facility Setting (Check One) ☐ Public ☐ Private ☐ Federal ☐ Unknown

Facility Type (Check One) ☐ Physician, HMO ☐ Hospital, Inpatient ☐ Other:

Residence at Diagnosis ☐ Unknown

City | County | State/Country | Zip Code

MODE OF TRANSMISSION (CHECK ALL THAT APPLY) (THIS INFORMATION CAN BE COMPLETED BY CASE MANAGEMENT)

☐ Sex with Male ☐ Sex with Female ☐ Injected nonprescription drugs

☐ Receiving clotting factor for hemophilia/coagulation disorder ☐ Received transplant of tissue/organs or artificial insemination

☐ Worked in a health-care or clinical laboratory setting, please specify:

☐ Received transfusion of blood/blood components (other than clotting factor)

HETEROSEXUAL RELATIONS WITH ANY OF THE FOLLOWING:

☐ Intravenous/injection drug user ☐ Transfusion recipient with documented HIV infection

☐ Transplant recipient with documented HIV infection ☐ Bisexual Male

☐ Person with hemophilia/coagulation disorder ☐ Person with AIDS or documented HIV infection

TREATMENT/SERVICES REFERRALS (THIS INFORMATION CAN BE COMPLETED BY CASE MANAGEMENT)

Has client been informed of his/her HIV infection? ☐ Yes ☐ No ☐ Unknown

This clients partners will be notified about their HIV exposure and counseled by:

☐ Health Department ☐ Physician/Provider ☐ Patient ☐ Unknown

This client is receiving or has been referred for: ☐ HIV-related medical services ☐ Substance abuse treatment services

This client is receiving or has received: ☐ Anti-retroviral Therapy ☐ PCP Prophylaxis

This clients medical treatment is primarily reimbursed by: ☐ Unknown ☐ No Coverage ☐ Clinical Trial

☐ Medicaid ☐ Private Insurance/HMO/PPO ☐ Other Public Funding: Identify

Government Program(s): ☐ Medicare ☐ Title I ☐ Title II ☐ Title III ☐ Title IV ☐ Veteran's Benefits (VA)

LABORATORY DATA (THIS INFORMATION MUST BE COMPLETED BY PHYSICIAN OR PHYSICIANS REPRESENTATIVE)

TEST	POS/NEG	Mo	Yr	TEST	Mo	Yr	MOST RECENT LABORATORY RESULTS	
HIV-1 Western Blot				CD4			Count (cells):	
Hepatitis A				Viral Load			Detectable Viral Load (copies):	
Hepatitis B				Has the client ever been tested at another state? ☐ No ☐ Yes, Where?				
Hepatitis C								

CLINICAL STATUS (THIS INFORMATION MUST BE COMPLETED BY PHYSICIAN OR PHYSICIANS REPRESENTATIVE)

AIDS Indicator diseases	Initial Diagnosis		Initial Date		AIDS Indicator diseases	Initial Diagnosis		Initial Date	
	Def	Pres	Mo	Yr		Def	Pres	Mo	Yr
Candidiasis, bronchi, trachea, or lungs					Lymphoma, immunoblastics (or equivalent term)				
Candidiasis, esophageal					Lymphoma, primary in brain				
Carcinoma, invasive cervical					Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary				
Coccidioidomycosis, disseminated or extrapulmonary					M. tuberculosis, pulmonary				
Crypococcosis, extrapulmonary					M. tuberculosis, disseminated or extrapulmonary				
Cryptosporidiosis, chronis intestinal (>1 mo. Duration)					Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary				
Cytomegalovirus rentinitis (with loss of vision)					Pneumocystis carinii pneumonia				
HIV encephalopathy					Pneumonia, recurrent, in 12 mo. Period				
Herpes simplex: chronic ulcer(s) (>1 mo. Duration); or bronchitis, pneumonitis or esophagitis					Progressive multifocal leukoencephalopathy				
Histoplasmosis, disseminated or extrapulmonary					Salmonella septicemia, recurrent				
Isosporiasis, chronic intestinal (>1 mo. Duration)					Toxoplasmosis of brain				
Kaposi's sarcoma					Wasting syndrome due to HIV				
Lymphoma, Burkitt's (or equivalent term)									

COMPLETED SECTIONS (ONCE SECTION IS COMPLETED, PLEASE INITIAL AND DATE TO ENSURE COMPLETETION FOR PHYSCIANS SIGNATURE)

SECTION	INITIAL	PRINT NAME OF PERSON COMPLETING INFORMATION	DATE COMPLETED
PATIENT HISTORY			
MODE OF TRANSMISSION			
TREATMENT/SERVICES REFERRALS			
LABORATORY DATA			
CLINICAL DATA			

PHYSICIANS SIGNATURE

PHYSICIANS SIGNATURE		DATE SIGNED	
PHYSICIANS NAME (PRINTED)			
NAME OF PERSON COMPLETING FORM			

PLEASE RETURN COMPLETED AND SIGNED FORM TO BELOW NOTED RYAN WHITE CASE MANAGER

CASE MANGER			PHONE			
AGENCY NAME			FAX			
ADDRESS (CITY/STATE/ZIP)	CITY		STATE		ZIP CODE	

Physicians are required to submit the above information as noted in KSA 65-6002, KSA 65-6003 and KSA 65-101. Submission of this form constitutes the above noted obligations.